ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

INTERNAL MEDICINE IN FRANCE- A REFLECTIVE REPORT

What are the most prevalent multi-system disorders encountered by an internist in France? How do they differ from the UK?

Internal medicine in France is the speciality that is concerned with managing patients with multi-system disorders which do not exclusively fit within the scope of a single speciality. Its specialists aim at providing an approach more comprehensive than the focused specialist's view but still more elaborate than the primary General Practitioner's (GP) care for patients with general, complex and sometimes rare pathologies. As such, it is sometimes viewed as the missing link between Pediatrics and Geriatrics.

I worked at the Internal medicine department of the Saint Eloi teaching hospital in Montpellier, a city with a fairly multicultural population in southern France. The department has 4 units: DIAGORA (Diagnostic Orientation Rapide), a step down from the Accident & Emergency department, an Addictology ward, a Vascular disease ward, and lastly a multi-organ disease ward. My discussion will be based on my experience at the multi-organ disease ward.

The patients admitted into the ward came in with varied presenting complaints ranging from elderly patients after unexplained falls & an altered general state, to patients where a multi-organ disorder such as a vasculitis was suspected. As well as patients with other general medical pathologies such as community acquired pneumonia. This I found to be very similar to the patients under the care of the general medics in the UK. Patient demographic was often comprised of elderly persons with a long history of medical problems, usually quite complex, that required we dedicate non-negligible amounts of time to information hunting - contacting GPs, family, etc.

However, in contrast to the UK, I also did come across patients with autoimmune diseases such as the vasculitides (Wegener's granulomatosis/ granulomatosis with polyangiitis, giant cell arteritis and polymyalgia rheumatica), systemic lupus erythematosus (SLE), Sjögren's syndrome and Scleroderma. These patients usually had established diagnostics, were known of the service and as was often the case would be admitted due to a relapse of their disease.

Some other cases proved more challenging than usual as patients would present with symptoms which could not be tied to a particular speciality, or example a patient who was thought to have a paraneoplastic syndrome, and later on diagnosed with a B cell lymphoma. On reflection, it was really good to see such a range of patients in a single ward.

The main difference in the practice of Internal medicine in France and the UK is that, Internal medicine or General Internal Medicine (GIM) as it is referred to in the UK can be practiced in either of two ways. It is a stand alone specialty when it is aimed at the management of acute emergencies, or it is usually paired with another medical speciality, e.g Diabetes and Endocrinology/General medicine or

Respiratory/General medicine. Doctors who work in this field usually will come to manage patients with complaints linked to their own speciality and then, much like in France, encounter another set of patients with multiple conditions. The latter frequently pose a diagnostic challenge and may require supplemental input from other specialities. In this case, the GIM specialist is in charge of coordinating that care.

In France, the core competence of the internist is centered around the management of autoimmune diseases. In the UK, these fall in the arena of rheumatology. Rheumatology in France seems to focus more on conditions with predominant symptomatology of the musculoskeletal system. Many of the conditions I saw in the UK were in the context of a rheumatology placement. Nevertheless, the french demarcation is hardly a strict one as rheumatologist are then confronted with the multiple multi-organ diseases with a musculoskeletal presentation.

What is the structure of general medical services in France? What are the adaptations for patients with multi-system diseases? How does this differ in the UK?

The healthcare system in France is widely acclaimed as one of the best in the world, as mentioned in the World Health Organization (WHO) Health Care report (2000). France spends 11.8% of GDP on healthcare; much higher than the UK (9.4%) and other European countries . Patients have the choice to consult with either private or public health services depending on how they are available. Most GPs practice in liberal private practices where a handful of them cater for their patients. Specialists can be found both in public hospitals where they mostly serve a function of referral centers but also in private setups much like the GPs. Some specialties like internal medicine however are mostly hospital based because of the nature of the pathologies managed and procedures carried out.

In terms of expenditure, at a typical GP or specialist consultation, the patient would pay the fare upfront. This fare would be reimbursed at a later time. About 70% of the cost would be borne by the nation's social security health insurance . The rest would then be covered by a complementary but non compulsory medical insurance (usually private) subscribed by the patient. In the case of some chronic, expensive and/or disabling conditions the social security's health insurance can cover the patient's total health expenditures without having to advance the fare upfront.

As costs are borne by the patient and then reimbursed, patients have freedom of choice of where to receive health care services however there is financial incentive to encourage patients to consult with their freely chosen and declared reference GP first before a specialist (except for dentists, ophthalmologists, gynaecologists and psychiatrists) in what is called the "parcours de soins coordonné". Beyond this parcours, the reimbursement would be incomplete. Emergency medical services remain free and exempt of the GP's permission.

At the Internal Medicine department in Montpellier, the patients with chronic illnesses or those requiring diagnostic workup or treatment can be managed with either; Day, Week or complete hospitalisation; according to what their precise needs are, in addition to regular outpatient follow up. This permits the patient's care to co-ordinated effectively, makes having consultations from other specialties easier, as well as allowing better planning and fewer hospital visits for the patients. Other

adaptations include weekly multidisciplinary staff meetings, allowing patients with multi-system disorders to benefit from the expertise of other medical specialists and healthcare professionals.

In the UK, adaptation for patients with multi-system disease include; multidisciplinary team meetings to discuss an inpatient, and on an outpatient basis, there are combined clinics which exist within certain specialities, e.g. joint rheumatology and dermatology clinic or joint rheumatology and hand surgery clinic. These clinics allow the patient to get timely care, reducing the amount of hospital consultations. We also have day hospital but not week hospital as such, day hospital tends to be therapy based e.g. patients who receive regular blood transfusions, it is not really used for diagnostic workups. Patients who require admission for treatments such as intravenous immunoglobulins, will usually undergo complete admission and diagnostic work-ups are completed on an outpatient basis without admission.

Describe a recent/ongoing research project which is being carried out at the faculty in the field of internal medicine.

The department is part of the national multi-centre trial "ALEGORI" - studying the efficacy of BEVACIZUMAB in the form of nasal spray as treatment for epistaxis in Rendu-Osler's disease/ Hereditary Haemorrhagic Telangiectasia (HHT).

HHT is a rare but ubiquitous autosomal dominant genetic disease. It is characterised by abnormal angiogenesis leading to systemic arteriovenous malformations and mucosal angiomas. Over 95% of these patients are afflicted with recurrent epistaxis which occur randomly, spontaneously, frequently, usually leading to anemia that may require transfusion and are a source of social embarrassment .

The study aims at assessing the efficacy of Bevacizumab (an anti-angiogenic monoclonal antibody directed against vascular endothelial growth factor) as a treatment for the epistaxis in these patients. The study is multicenter, randomized controlled double blinded trial and has for primary outcome measure the mean duration of epistaxis 3 months after treatment with nasal Bevacizumab at three different dosages, versus placebo.

Started in 2014, this national study will include from 120 to 160 patients over a period of about two years. There are 4 groups/arms of 20 patients each corresponding to the placebo and 3 dosage groups (25mg, 50mg, 75mg). The drugs are administered repeatedly at the hospital on three occasions with a 14 days interval each time. Patients are followed up for up to 6 months after the treatment with ENT exam, genetics consultation, phone questionnaires and nosebleeds logging. Efficacy is assessed primarily by mean duration of epistaxis 3 months after treatment. Other outcomes assessed are tolerance and adverse effects, frequency of epistaxis, quality of life, number of blood transfusions, change in haemoglobin and serum ferritin levels.

To broaden my clinical, professional and linguistic skill sets in a French health and cultural setting

I feel that I was able to achieve the goal of improving my medical knowledge as this placement allowed me to see patients with rare autoimmune disorders, such as Wegener's disease, SLE and Scleroderma, and also allowed me to deepen my knowledge of the diseases and enlighten me on their atypical aspects which I was not versed with up to now. What I also took away from the placement, was the importance of precise and chronologic history taking and trying to piece the patient's story together. This is a very hard skill to master, especially with the complex patients that we encountered on the ward. In addition, I was able to witness the approach of the internist who thinks broadly and outside of the box, and is able to piece a diagnostic conundrum together.

With many diseases we encountered on the ward requiring the use of immunosuppressants, I was also able to appreciate the iatrogenic complications as a result of such treatments. Two-thirds of patients with SLE die as a result of the complications of corticosteroid therapy as compared to one-third from their disease. In a specialty where extensive investigations are carried out it also made me reflect on the difficult decisions doctors have to make when ordering investigations and starting treatments and whether such decisions will cause more harm than good. In addition, another rewarding aspect of this placement is that my french has improved significantly and I really enjoyed expanding my medical knowledge and linguistic knowledge simultaneously. Despite having difficulties at the start, I have thoroughly enjoyed my experience and I am very grateful for Professor LeQuellec and the rest of the medical team for being so welcoming and taking me under their wing.